Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS350AGC	A. BUILDING _____ B. WING _____	11/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ROSE RETIREMENT HOME I	3164 HEBARD DRIVE LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility from 8/4/10 to 11/18/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was five. One discharged resident's facility file and hospital record were reviewed. Facility caregivers, the resident, the resident's family and the resident's physician were interview during the investigation. Complaint #NV00026101 was substantiated. See Tags Y0850 and Y0851 The following deficiencies were identified:	Y 000	4/18/11 APOC SBell	
Y 850 SS=D	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the	Y 850		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Nurse Admin — (X6) DATE: 4/14/11

MARIANITA Gee

RECEIVED
APR 15 2011
BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

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Y 850	Continued From page 1 resident is the resident's physician is not available. This Regulation is not met as evidenced by: Based on interview and record review from 8/4/10 to 11/18/10, the facility failed to notify 1 of 5 resident's family members after the resident fell in the facility (Resident #1). Severity: 2 Scope: 2	Y 850 ✓ SB 4/18/11	TAG Y850 A) The administrator has instructed the caregivers on the proper format of incident Reporting, IAW NAC 449.274 B) Quarterly the ~~administrator~~ will assume the responsibility to reiterate the procedure to the staff how to report and alert the necessary authorities. C) 4/14/11	
Y 851 SS=G	449.274(1)(b) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (b) Request emergency services when such services are necessary. This Regulation is not met as evidenced by: Based on observation, interview and record review from 8/4/10 to 11/18/10, the administrator failed to ensure medical services were obtained for 1 of 4 residents who was injured after a fall in the facility (Resident #1).	Y 851		

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Y 851	Continued From page 2 Findings include: Resident #1 was admitted to the facility 7/22/10, was wheelchair bound, incontinent of bladder, hyperglycemic and anemic. The resident's file contained contact phone number for four family members. * On 8/4/10, the facility provided an incident report dated 7/25/10 completed by Employee #1 and Employee #2 that documented Resident #1's fell between 8:30 PM and 8:45 PM while being toileted in the bathroom. The incident report document the facility attempted to contact the resident's doctor and left a message. A handwritten note at the bottom of the form documented the facility attempted to notify one family member, but left a message and did not speak to anyone. * Home Health Agency (HHA) communication notes dated 7/26/10 and 7/27/10 documented that the physical therapist and nurse were told Resident #1 had a fall in the facility on 7/25/10; she lost her balance while getting up from the commode and landed on her right side. The resident reported having pain in the right hip area radiating to the right gluteal region at a level 6 on a 10 point scale. The primary caregiver stated the resident was being given pain medication. The primary caregiver at the facility was instructed to take the resident to the hospital if the pain got worse or there was a significant change in patient condition. A note describing the incident was faxed to the resident's doctor 7/27/10, she signed it and faxed it back as an acknowledgement on 7/28/10. * During an interview, Resident #1's doctor reported a caregiver left a phone message about	Y 851 ✓ SB 4/18/11	TAG Y851 A) The administrator has instructed the staff on the importance of NAC 449.274. The Relevance of reporting and the depth of observance of our Clients/Residence. We have expressed the Value of Communication between Dr's & family, our core defense to prolonged health issues. B) Owner/Administrator will work together to continue the Communication with our staff on a QTRLY Bases/As the occassion arises. C) 4/14/11	

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Y 851	Continued From page 3 the resident's fall. The doctor reported she called back the next day and the facility caregiver told her the resident was doing okay. The doctor stated she told the caregiver to monitor the resident and to take the resident to urgent care if she complained of pain. * A HHA nurse went to the facility and assessed Resident #1 again on 7/28/10. The HHA nurse documented the resident's pain level was at 7 on a 10 point scale but was reduced to a level 4 on a 10 point scale after use of pain medication. * On 7/28/10, family members of Resident #1 picked the resident up from the facility for a family dinner and sleep over. Family reported they were not aware the resident had fallen in the home until they were told by the facility caregiver. Family members reported the resident was complaining of pain in her right hip during and after dinner. The family took the resident to the hospital the next morning. * An emergency room nursing record from the hospital documented Resident #1 was admitted on 7/29/10 at 10:20 AM with a chief complaint of right hip pain that began four days prior. Resident #1 was diagnosed with an acute intertrochanteric fracture of the hip and right superior pubic ramus fracture that required surgery. The resident had right hip surgery on 7/30/10. Based on interviews with facility caregivers, family members and Resident #1, the facility failed to seek medical treatment for Resident #1 when she continued to complain of right side pain. The facility failed to follow advice from Resident #1's home health agency nurse and the resident's physician to seek medical services if the resident	Y 851		

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Y 851	Continued From page 4 complained of continued pain. The facility allowed the resident to be in pain for over three days and caused delays in treatment for the resident's injury which ultimately required surgery for fractures of the right hip. Severity: 3 Scope: 1	Y 851		